AUTHORIZATION: RELEASE OF INFORMATION FORM

AN:
SD:
MN:
PN:
BD:
AP:

Patient Name: _____ Date of Birth: _____

Telephone Number: _____ Social Security #: _____

Address: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. I authorize – Name: _____

   Address: _____

   To: ☐ Release records to ☐ Obtain records from ☐ Exchange information with

   Name: _____

   Address: _____
3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information such as dates where indicated) ***and has been generated prior to the signing of this authorization.***
   - ☐ Emergency room report (date) _____
   - ☐ Operative report (date) _____
   - ☐ Pathology report (date) _____
   - ☐ History & physical report (date) _____
   - ☐ Most recent discharge summary (dates) from _____ to _____
   - ☐ Lab results (dates) from _____ to _____
   - ☐ X-ray and imaging reports (dates) from _____ to _____
   - ☐ Consultation reports (dates) from _____ to _____
   - ☐ Entire record (dates) from _____ to _____
   - ☐ Other (please describe) _____
4. I authorize the entity or person listed in #2 above to release information from my record that may include the following:

YES	NO	
☐	☐	Behavioral or mental health services
☐	☐	Treatment of alcohol and / or substance (drug) abuse
☐	☐	Testing for HIV, HIV test results, diagnosis of HIV positive, AIDS, ARC or other AIDS related disease.
5. The purpose of the release of these records is ☐ Personal use ☐ Continuation of medical care
   - ☐ Pending legal action ☐ Insurance company or other third party reimbursement
   - ☐ Other (please describe) _____
6. I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless I specify differently, this authorization will expire (date or event) _____ or if I fail to specify, this authorization will expire ***one year*** from the date of the signature.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Note: With the exception of records being copied for continuity of care or insurance company or other third party reimbursement, there WILL be a charge for copies of records.

_____/_____ _____/_____

Signature of patient or patient's representative Date Signature of witness Date

If signed by patient's representative, relationship to patient: _____

If patient representative, provide documentation or explanation of your authority to act for the patient. (Attach copy.)

- Administrative Use Only –

Driver's license number: _____